



State of Utah

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Department of Human Services

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Executive Director

Division of Substance Abuse and Mental Health

DOUG THOMAS
Director

March 26, 2019

Commissioner Kenneth Maryboy
San Juan County Commission
333 S. Main, #2
Blanding, UT 84511

Dear Commissioner Maryboy:

In accordance with Utah Code Annotated 62A-15-103, the Division of Substance Abuse and Mental Health has completed its annual review of San Juan Counseling Center and the final report is enclosed. The scope of the review included fiscal management, children, youth, family and adult mental health services, substance abuse treatment and prevention services, and general operations.

The center has many strengths; however, this report by its nature focuses on the exceptions and areas in need of improvement. The Division has approved all corrective action plans submitted by the Center/County in response to each reported finding, which have been included in the final report. If you have any questions, please contact Chad Carter (801)538-4072

We appreciate the cooperation and assistance of the staff and look forward to a continued professional relationship.

Sincerely,

Doug Thomas

Doug Thomas
Division Director

Enclosure

cc: Commissioner Willie Grayeyes, San Juan County Commission
Tammy Squires, Director of San Juan Counseling Center



Site Monitoring Report of

San Juan Mental Health/ Substance Abuse Special Service District
DBA San Juan Counseling Center

Local Authority Contracts #152314 and #152315

Review Date: October 16, 2018

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Section One: Site Monitoring Report

Executive Summary

In accordance with Utah Code Section 62A-15-103, the Division of Substance Abuse and Mental Health (also referred to in this report as DSAMH or the Division) conducted a review of San Juan Counseling Center (also referred to in this report as SJCC or the Center) on October 16, 2018. The focus of the review was on governance and oversight, fiscal management, pediatric and adult mental health services, substance abuse prevention and treatment services and general operations.

The nature of this examination was to evaluate the Center’s compliance with: State policies and procedures incorporated through the contracting process; Division Directives; State mandated mental health services; and Preferred Practice Guidelines. During the examination, the review teams evaluated: the reliability and integrity of the Center’s data and its compliance with established programmatic and operational objectives. Additionally, the review included an examination, through sampling, of the Center’s efficient and appropriate use of financial resources.

Summary of Findings

Programs Reviewed	Level of Non-Compliance Issues	Number of Findings	Page(s)
<i>Governance and Oversight</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Child, Youth & Family Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 2 None	10-12
<i>Adult Mental Health</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None None	
<i>Substance Abuse Prevention</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None None 3	17-18
<i>Substance Abuse Treatment</i>	Major Non-Compliance Significant Non-Compliance Minor Non-Compliance Deficiency	None None 1 None	21-22

Governance and Fiscal Oversight

The Division of Substance Abuse and Mental Health (DSAMH) conducted its annual monitoring review of San Juan Counseling Center (SJCC). The Governance and Fiscal Oversight section of the review was conducted on October 16, 2018 by Chad Carter, Auditor IV. Overall cost per client data was analyzed and compared to the statewide Local Authority average. Personnel and subcontractor files were examined for compliance with state licensing laws and adherence to contractual requirements, as well as the Center’s own policy. Executive travel reimbursements were reviewed to ensure they were appropriate and that no personal benefit has been gained. Board minutes were reviewed and discussions were conducted to determine if an appropriate level of involvement and financial oversight was provided by the governing board and/or the contracted County.

As part of the site visit, San Juan Counseling sent several files to demonstrate their allocation plan and to justify their billed amounts. The allocation plan is clearly defined and shows how administrative and operational costs are equitably distributed across all cost centers and that the billing costs for services are consistently used throughout the system.

The CPA firm Smuin, Rich & Marsing completed an independent audit of San Juan Mental Health/Substance Abuse Special Service District for the year ending December 31, 2017. A single audit was not done as SJCC did not receive enough Federal funding to meet the \$750,000 threshold to require a single audit for this year. The auditors issued an unqualified opinion in the Independent Auditor’s Report dated June 15, 2018. There were no findings or deficiencies reported.

Follow-up from Fiscal Year 2018 Audit:

No findings issued in FY18.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) Federal guidelines require that subrecipients have written policy and procedures that address Federal procurement standards and Federal award procedures. This issue was discussed with SJCC. A check for these policies was added to monitoring this year as the Division is taking steps to ensure compliance with Federal regulations. It is recommended that SJCC take steps to have written policies in place to address requirements listed in 2 CFR 200 regarding procurement, Uniform Guidance cost principles and terms and conditions of Federal awards. Failure to have these policies in place will be addressed as a finding in following years.

FY19 Division Comments:

- 1) The board reviews and approves all executive travel. In the previous year, it was recommended that SJCC provide the board with the separate travel approval sheets to give a more detailed account of travel expenditures. SJCC did start providing the travel approval sheets to the board this year as part of the approval process. DSAMH appreciates SJCC's willingness to ensure there is sufficient transparency and oversight regarding executive travel.

Mental Health Mandated Services

According to Utah Code 17-43-301, the Local Authority is required to provide the following ten mandated services:

Inpatient Care

Residential Care

Outpatient Care

24-hour Emergency Services

Psychotropic Medication Management

Psychosocial Rehabilitation (including vocational training and skills development)

Case Management

Community Supports (including in-home services, housing, family support services, and respite services)

Consultation and Education Services

Services to persons incarcerated in a county jail or other county correctional facility

The mandate to provide services to those in county correctional facilities is not applicable to the children and youth population.

In subsection (4)(a)(ii) each local authority is required to “annually prepare and submit to the Division a plan approved by the county legislative body for mental health funding and service delivery, either directly by the local mental health authority or by contract.” This annual area plan provides the state Division of Substance Abuse and Mental Health with a measuring tool against which the local authority is measured during the annual monitoring site review.

A major focus of the monitoring efforts of the Division of Substance Abuse and Mental Health is to measure compliance with this legislative mandate to provide these services to the adults, youth, and children of Utah.

Child, Youth and Family Mental Health

The Children, Youth, & Families team conducted its annual monitoring review at San Juan Counseling Center on October 16, 2018. The monitoring team consisted of Mindy Leonard, Program Manager and Tracy Johnson, Utah Family Coalition (Allies With Families). The review included the following areas: record reviews, discussions with clinical supervisors and management, case staffing, program visits, allied agency visits, and feedback from families through questionnaires and a feedback group. During the visit, the monitoring team reviewed the Fiscal Year 2018 audit; statistics, including the Mental Health Scorecard; Area Plans; Youth Outcome Questionnaires; family involvement; Family Resource Facilitation (Peer Support); High Fidelity Wraparound; Multi-Agency Coordinating Committee; school-based behavioral health; Mental Health Early Intervention Funding; juvenile civil commitment; compliance with Division Directives; and the Center’s provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2018 Audit

FY18 Minor Non-compliance Issues:

- 1) *Youth Outcome Questionnaire (YOQ)*: The frequency the YOQ is being administered at is below the required guidelines of “every thirty days or every visit (whichever is less frequent)” as described in the Division Directives. In the chart review, YOQs were being administered approximately four times in the last calendar year. There is also continued evidence that the YOQ is not being addressed in the clinical process. Within the chart review, the YOQ was not utilized throughout the treatment process, either in the treatment plan or when a red flag is identified, with only one chart referencing the YOQ clinically. SJCC has made good progress in the rate of at least two YOQ administrations throughout FY17, with the rate being increased from 44.2% in FY16 to 62.7% in FY17.

This issue has not been resolved and will be continued in FY19; see Minor Non-compliance Issue #1.

FY18 Deficiencies:

- 1) Psychosocial Rehabilitation (PSR): SJCC has decreased the rate of Psychosocial Rehabilitation provided from 3.4% in FY16 to .4% in FY17 with a total of one youth being served. Psychosocial Rehabilitation is one of the ten mandated services as required by Utah Code 17-43-301.

This issue has been resolved. There has been a major increase in PSR services from .4% of youth receiving the service in FY17 to 4.2% of youth receiving this service in FY18. The increase was at a rate of 110%.

- 2) Respite Services: SJCC provided Respite services at a lower rate than the rural and State averages. In FY17, Respite services were provided at a rate of 0.9 %, which was a decrease of 2.5% from FY16. SJCC provided Respite services to two youth during FY17. Respite is one of the ten mandated services as required by Utah Code 17-43-301.

This issue has not been resolved and will be continued in FY19; see Minor Non-compliance Issue #2.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) Youth Outcome Questionnaire: SJCC does not administer the Youth Outcome Questionnaire (YOQ) at least once every 30 days. The Division Directives state “DSAMH will require that the Youth Outcome Questionnaire be given to patients and consumers at intake, every thirty days or every visit (whichever is less frequent), and at discharge/discontinuation (inpatient stays for community mental health are exempt).” Through records reviews, eight of the ten charts reviewed had YOQs that were not administered at the required frequency of at least once every 30 days.

Center’s Response and Corrective Action Plan:

Center’s response: San Juan Counseling recognizes the value of tracking client outcomes through objective instruments like the Youth Outcome Questionnaire (YOQ). From August 15, 2018 to February 28, 2019, SJC clinicians have counseled 216 children and youth ages 17 and younger. Of those, approximately 62% (134 students) were seen in a school setting with 16% of the youth (34 students) in the school setting being 9 years of age or younger. Obtaining consistent YOQ scores with students in the school setting is more challenging given the lack of secretarial support for the clinician who is often seeing the student within in very tight window of time. And for the 16% of students too young to complete the YOQ on their own, the challenge of contacting the parents monthly (or even quarterly) by phone is quite difficult. To date, we have had BSW interns make outbound phone calls to parents and guardians but with limited success.

Action plan:

- 1. Provide annual training to all clinical staff on the functionality, utility and interpretation of the YOQ instruments. A 2-hour training was held on January 23, 2019 that was attended by all clinical staff. Newly hired clinical staff will be trained on the OQ instruments as part of new employee orientation.
- 2. All clinicians meeting with youth in a school-based setting will have the off-line version of the OQ instruments installed on their laptop computers and receive training on how to administer and upload completed questionnaires.
- 3. SJC secretarial staff will review each therapist’s schedule on a weekly basis and note those clients needing a YOQ to prompt the therapist and/or front office staff of the need for the YOQ to completed in that session.

4. BSW interns will continue to make outbound phone calls to parents of children 9 years old and younger seen in the school setting.

5. SJC clinicians will receive a monthly e-mail listing all children and youth who have not completed a YOQ within the past 30 days. This will be done for 3 months and evaluated for effectiveness and, if so, will be continued. Clinical staff will also be instructed in the importance of this objective as part the action plan we are committing to with the DSAMH.

Timeline for compliance:

1. All clinical staff (including MSW interns) will receive training in the YOQ instrument annually by July 31, 2019.

2. The off-line YOQ has been downloaded on the computers of all school-based therapists.

3. Starting March 1, 2019, SJC secretarial staff will begin weekly review of therapist schedules and mark all clients who have not had an YOQ within the past 30 days.

4. BSW interns will devote at total of 4 hours per month to making outbound phone calls to parents in March, April and May 2019.

5. SJC clinicians will begin receiving a monthly e-mail as of March 2019 listing their clients needing a YOQ.

Person responsible for action plan: Ryan Heck, Clinical Director

- 2) Respite Services: SJCC continues to provide Respite services at a low rate. In FY18, only one youth received Respite services, which decreased from the two children who received Respite services in FY7. Respite is one of the ten mandated services as required by Utah Code 17-43-301.

Center’s Response and Corrective Action Plan:

- Center’s response: San Juan Counseling has provided respite services in response to clients in crisis on an as needed basis, utilizing adult case managers and family resource facilitators. We can seek to improve these services by more regularly identifying youth who could benefit prior to a crisis occurring.

Action plan:

1. The SJC clinical team will be invited quarterly to review their caseloads for youth eligible for and in need of respite services and identify at least 3 qualifying youth.

2. Respite will be scheduled during office hours and assigned to an SJC case manager.

3. The clinical director will coordinate monthly with the day treatment program director to review respite assignments made to case managers to help ensure respite services are continuously provided.

4. Our current FRF (who will be transitioning out of her current position by September 2019), will provide a training to our CM team in respite and child case management services.

Timeline for compliance:

1. Therapists will be asked to review their caseloads quarterly, starting March 2019.

2. Respite services will begin by April 15, 2019 and be provided during office hours by certified case managers.

3. The clinical director and day treatment program manager will begin meeting on this subject monthly starting March 1, 2019.

4. The FRF will provide a training to CM staff by May 2019.

Person responsible for action plan: Ryan Heck, Clinical Director
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FY19 Deficiencies:

None

FY19 Recommendations:

None

FY19 Division Comments:

- 1) Family Feedback: The Utah Family Coalition (UFC) collected 17 questionnaires from the families who receive services, while three parents/caregivers and two youth attended the focus group. Families and youth stated the staff tried to accommodate their needs and were helpful, they were able to get in quickly for therapy and medication management. Most individuals have safety plans, understand the plan, and participated in creating the plan. They know when they are improving and are involved in many community activities. Most individuals completing the questionnaire stated that they were included in the treatment planning with their child. Specific comments included, “the FRF is out in the community doing a great job representing the Center”. It was mentioned by all the families they serve that the FRFs go above and beyond for them.
- 2) School-Based Behavioral Health (Partnership): SJCC provides a group with the local schools through School-Based services. The FRF has been providing the group using the Zones and Regulations curriculum. All local schools have HOPE squads. The team has been culturally sensitive to the Southern Utah schools and have renamed them the Unity Squads.

Adult Mental Health

The Adult Mental Health team conducted its annual monitoring review of San Juan Counseling Center on September 10-11 and October 16, 2018. The team included Mindy Leonard, Program Manager, Pete Caldwell, Program Manager, Sharon Cook, Program Manager and Cami Roundy, Program Manager. The review included the following areas: discussion with the clinical director, record reviews, and a site visit to the San Juan County Jail. During the discussion, the team reviewed the FY18 audit; statistics, including the Mental Health Scorecard; area plans; Outcome Questionnaires and the center’s provision of the ten mandated services as required by Utah Code 17-43-301.

Follow-up from Fiscal Year 2018 Audit

No findings were issued in FY18.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) Peer Support Services (PSS): The FY18 Scorecard continues to report services significantly below the rural average (SJCC-1.6%; rural average-4.4%). Peer Support Services have been recognized as an Evidence-Based Practice by the Centers for Medicare and Medicaid Services (CMS) since 2007. Although SJCC has some Peer Support services provided by a Family Resource Facilitator, it is recommended that SJCC continue efforts to employ an adult Certified Peer Support Specialist in order to expand this service to a wider range of adult clients.
- 2) Case Management (CM): SJCC continues to report a level of CM services that are significantly lower than the State rural average (SJCC-10.9%; rural average-34.7%). Case management is one of ten mandated services listed in Utah Code 17-43-301. While it is encouraging that inpatient numbers remain low, SJCC is encouraged to ensure CM is available when needed, demonstrate that the need is already adequately addressed, and/or demonstrate how these needs are filled in ways other than Case Management.

- 3) Administration and Use of the Outcome Questionnaire (OQ): A review of documentation demonstrated that the OQ was administered in six of nine charts. Two charts had no evidence of OQ administration and one chart included a comment that the client was visually impaired and chose not to take the OQ. When the OQ score was present, a self-administered Severe Outcome Questionnaire (S-OQ) had been completed with the assistance of a case manager. One of eight charts included evidence that the OQ had been reviewed between the client and the therapist. The other charts did not show evidence of OQ review either with the case manager or the therapist. Division Directives require that the data from the OQ be shared with the client and incorporated into the clinical process, as evidenced in the chart.
- 4) Documentation: In accordance with Preferred Practice Guidelines and ongoing planning principles, short term goals/objectives are to be measureable, achievable and within a timeframe. Six of nine charts reviewed demonstrated objectives that were not measureable (ie. “learn skills”, “practice skills”, “improve skills”). Three of five charts internally reviewed by SJCC also did not contain measurable objectives. One possible option for developing measurable goals is encouraging staff to utilize SMART goals; Specific, Measurable, Attainable, Relevant, and Time-based.

FY19 Division Comments:

- 1) Employment Services/Supported Education: SJCC hired an employment specialist to provide supported employment services by operating closely to the Individual Placement and Support (IPS) model. Their lead employment specialist spends a portion of her time meeting with employers and educates them on hiring and retaining individuals with mental illness. SJCC has a limited number of jobs in their area; however, they are aware of a high need to create jobs, specifically in the Montezuma Creek area. SJCC has developed a consumer-run business. There is no expectation that clients need to be employed by the created business. Adhering to the IPS model, if that is the client’s interest, it would be a job option. In addition to the employment specialist, SJCC has integrated case managers to provide IPS employment services to mental health and substance use disorder clients.
- 2) Services for Incarcerated Individuals: DSAMH commends the partnership developed between SJCC and the San Juan County Jail. Through strong collaboration, people in the jail are transported to and from the Utah State Hospital and regular mental health assessments are completed. Jail intake staff complete a suicide assessment at each intake. Two therapists on the jail staff run a sex offender group. The jail is beginning to use telehealth services when appropriate in order to get people the help they need. SJCC’s efforts to grow programming in the jail are also noteworthy.
- 3) Suicide Prevention: The San Juan community is commended for a robust collaboration effort for suicide prevention. The Utah Navajo Health System (UNHS) provides backbone support and leadership, and SJCC is an active participant. UNHS has projects that include a firearm safety grant and ongoing gatekeeper training, in addition to a previous Prevention by Design grant.

- 4) Community Partnerships: SJCC has demonstrated collaborative efforts with the San Juan Health Department, including reaching out to provide specialized care to clients struggling with perinatal mental health issues. It is expected that colocation of offices will strengthen efforts to integrate services across these agencies.

Substance Abuse Prevention

Craig PoVey, Prevention Administrator, conducted the annual prevention review of San Juan Counseling on October 16, 2018. The review focused on the requirements found in State and Federal law, Division Directives, and contracts. In addition, the review evaluated the services described in the annual prevention area plan and the data used to establish prevention priorities.

Follow-up from Fiscal Year 2018 Audit

FY18 Minor Non-compliance Issues:

- 1) SJCC did not complete a full community assessment. No community readiness assessment was completed. The Division Directives require each local authority to assess local prevention needs based on epidemiological data.

This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data and additional local data.

1. Assessments shall be done at minimum every three years.

2. Resources that shall be used to perform the assessment include, but are not limited to:

(a) <http://bach-harrison.com/utsocialindicators.html>

(b) <http://ibis.health.utah.gov>

(c) Communities that Care, Community Assessment Training (CAT)

<http://www.communitiesthatcare.net/getting-started/ctc-training/>.

This finding has not been resolved and will be continued in FY19 as a deficiency; see Deficiency #3. SJCC has made significant progress by gathering data from medical facilities throughout the county, using SHARP data where possible, and interviewing key leaders. The full community assessment has not been compiled and turned in.

FY18 Deficiencies:

- 1) No Eliminating Alcohol Sales to Youth (EASY) compliance checks occurred in FY18.

This finding has not been resolved and will be continued in FY19; see Deficiency #1.

- 2) Currently SJCC's Synar compliance rate is 77%. Division Directives measure for a compliance rate of 90%.

This finding has not been resolved and will be continued in FY19; see Deficiency #2.

- 3) SJCC programming is only 50% evidence based. The Division Directives require a goal of 80%.

This finding has been resolved. SJCC now meets Division Directives requirement of 80% evidence based programming.

Findings for Fiscal Year 2019 Audit

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

None

FY19 Deficiencies:

- 1) No Eliminating Alcohol Sales to Youth (EASY) compliance checks occurred in FY18.

Center’s Response and Corrective Action Plan:

Action Plan: Working with recently elected County Sheriff to find ways that we can support them in conducting EASY checks. Feel he will be responsive. No checks were completed last year.

Timeline for compliance: End of fiscal year 2019

Person responsible for action plan: Alyn Mitchell – Coordinator

- 2) Currently SJCC’s Synar compliance rate is 70%. Division Directives require a compliance rate of 90%.

Center’s Response and Corrective Action Plan:

Action Plan: Working with Public Health to support them in strategizing ways to achieve greater compliance percentages. Youth coalition kids helped in tobacco buys. Waiting for a response from Public Health on what the current percentages are for 2019.

Timeline for compliance: End of fiscal year 2019

Person responsible for action plan: SJCPAC Coalition / Public Health / Alyn M. – Coordinator

- 3) SJCC did not complete a full community assessment. The Division Directives require each local authority to assess local prevention needs based on epidemiological data.
This assessment shall include the most current Student Health and Risk Prevention Survey (SHARP) data and additional local data.

- 1. Assessments shall be done at minimum every three years.
- 2. Resources that shall be used to perform the assessment include, but are not limited to:
 - (a) <http://bach-harrison.com/utsocialindicators.html>
 - (b) <http://ibis.health.utah.gov>
 - (c) Communities that Care, Community Assessment Training (CAT)
<http://www.communitiesthatcare.net/getting-started/ctc-training/>.

Center’s Response and Corrective Action Plan:

<p>Action Plan: Working on the development of continued strategies for assessing San Juan County Communities to obtain necessary data for a full community assessment. Have conducted Community Readiness Assessments in Blanding and Monticello Communities. This data has been compiled and scored. Currently working with Regional Director to fine-tune and complete. Surveys were taken in the communities of Montezuma Creek, White Mesa and Monument Valley as well, however the number of surveys needed was not the amount needed for full assessment. We have hired a new Prevention Specialist who will be primarily focused on completing new community assessments in various county communities. We are also working very hard as a coalition to obtain permission from the Navajo Tribe to conduct SHARP Surveys in our southern schools, who currently do not participate in the Survey. This has been our primary focus in the assessment phase. We have obtained all Chapter House (5) approvals needed and are waiting to appear before the Northern Tribal Council, and the Western Tribal Council in March as a final step in the approval process.</p> <p>Timeline for compliance: End of Year (December 2019)</p> <p>Person responsible for action plan: Coalition Members / Shauna Sherrow – Prevention Specialist / Alyn M. - Coordinator</p>

FY19 Recommendations:

- 1) Continue community readiness work and developing capacity in communities throughout the LSAA area. Work with the State Epidemiology/Outcomes Workgroup (SEOW) to develop a plan to gather data for community assessments, then prioritize communities throughout the LSAA and increase the level of community centered evidence based prevention services.
- 2) Work with Utah Behavioral Health Committee’s prevention network to plan and implement strategies to increase the number of EASY compliance checks.
- 3) Deploy strategies to increase compliance of tobacco outlets.

FY19 Division Comments:

- 1) SJCC increased the number of communities that have been assessed for willingness and ability to deploy evidence based prevention services, but data constraints for this area has been a barrier to completing community assessments.

- 2) The coalition has broadened and become more reflective of the community. SJCC increased evidence based prevention programming from 50% last year to 83% this year.

Substance Use Disorders Treatment

Becky King, Program Administrator for Substance Use Disorder Services conducted the monitoring review on October 16, 2018. The review focused on compliance with State and Federal laws, Division Directives, Federal Substance Abuse Treatment (SAPT) block grant requirements, JRI, scorecard performance, and consumer satisfaction. The review included a document review, clinical chart review, and an interview with the clinical director and other staff members. Consumer satisfaction and performance were also evaluated using the Division Outcomes Scorecard, and the Consumer Satisfaction Scorecard.

Follow-up from Fiscal Year 2018 Audit

FY18 Minor Non-compliance Issues:

- 1) Data from the FY17 Utah Substance Abuse Treatment Outcomes Scorecard showed that the percent of non-homeless clients from admission to discharge was 0%. The State average in FY17 was 2.5%.

This finding has been resolved. The percent of non-homeless clients from admission to discharge continues to be 0%, which indicates stability in housing. The finding from last year was inaccurate.

- 2) Treatment Episode Data Set (TEDS) submissions did not reflect if 31.9% of incoming clients have been “compelled to treatment” by the criminal justice system. A maximum of 10% of clients could be unknown for this field according to the 2017 data specifications. This information is necessary to track outcomes related to Utah’s Justice Reinvestment Initiative.

This finding has been resolved. In FY18, 100% of the data was collected for clients compelled to treatment in the criminal justice system upon admission: 61.1% reported being compelled while 38.9% reported not being compelled to treatment.

FY18 Deficiencies:

- 1) Client charts lacked information on whether a client was offered, or using Medication Assisted Treatment (MAT) to assist with their recovery. If MAT was offered, it was recommended that the client’s progress be documented and that a urinalysis test be conducted to confirm the use of MAT.

This issue has been resolved. The clients charts now show that clients are being offered or using Medication Assisted Treatment (MAT) to assist with recovery efforts.

- 2) Client charts did not indicate if tobacco cessation was offered to clients who reported tobacco use. Upon talking with the center, there were no specific groups they offered on tobacco cessation, but stated they would look into online support groups.

This issue has been resolved. The clients charts now show that tobacco cessation is being offered clients who report tobacco use. SJCC is planning to distribute Recovery Plus resources to clients and discuss tobacco cessation in group, individual sessions and medical appointments.

Findings for Fiscal Year 2019 Audit:

FY19 Major Non-compliance Issues:

None

FY19 Significant Non-compliance Issues:

None

FY19 Minor Non-compliance Issues:

- 1) Data from the FY17 Utah Substance Abuse Treatment Outcomes Scorecard and TEDS shows:
 - a) The percent change, admission to discharge, in clients using social recovery supports decreased from 39.7% to -14.2% from FY17 to FY18 respectively, which does not meet Division Directives.
 - b) The percent change, admission to discharge, of tobacco use for clients moved from 14.7% to -13.3% from FY17 to FY18 respectively, which does not meet Division Directives.
 - c) Out of 33 admissions that were compelled to treatment, criminogenic risk factors were not collected for 21 admissions, which is 63.6%. Only 10% of compelled admissions can be unknown for criminogenic risk. This does not meet Division Directives.

Center’s Response and Corrective Action Plan:

Center’s response: Many of the problems with the SJC TEDS data has been due to oversights in the training of our clinical team. For instance, after our October 2018 site visit, we learned our primary substance abuse therapist was entering the justice risk level for all adult clients as “not collected,” even if a RANT had been completed. This has since been clarified and corrected. Nevertheless, continued training is needed to help the clinical team understand the importance of the data set and how to accurately enter the data, particularly as client circumstances change over time.

Action plan:

- 1. Provide training to clinical staff on correctly recording criminogenic risk factors (i.e. RANT results) in the EHR.
- 2. Enable to all our substance abuse counselors to complete the RANT in the event a client has not had opportunity to complete the instrument with the Recovery Support Coordinator.
- 3. Hold an annual training for all clinicians on TEDS data and how to correctly collect and enter the data within the EHR. Important data points, such as use of social recovery supports, tobacco use and criminogenic risk factors will be emphasized. This training will also be included in new employee orientation for therapists and MSW interns.

<p>Timeline for compliance:</p> <ol style="list-style-type: none">1. The clinical director met with the primary outpatient substance abuse therapist in the agency in November 2018 and explained how to correctly enter the RANT data so it is reported in TEDS. Since that time, 5 out of 7 (71%) of the clients she has seen for an intake substance abuse intake have a risk level indicated in TEDS.2. Katie Eberling, CSW will be trained in completing the RANT and entered as user in the RANT data base by April 2019. This will enable her to enter the data when a client has not been first seen by the Recovery Support Coordinator.3. A TEDS data training has been scheduled with the clinical team on Wednesday, March 27, 2019 at 9:00 a.m. <p>Person responsible for action plan: Ryan Heck, Clinical Director.</p>

FY19 Deficiencies:

None

FY19 Recommendations:

- 1) Drug Court and Criminal Justice Documents: The following Drug Court documents were not attached and scanned to the clinical charts: (1) Signed fee agreement (2) drug testing agreement and urinalysis results (3) consent form (4) intake documents, including the privacy statement with signatures / witness signatures (5) Criminogenic Risk Tools (LSIR&R and RANT). It is recommended that SJCC continue to work on scanning and attaching these documents to the client’s charts.

FY19 Division Comments:

- 1) Collaboration and Integration of Services: SJCC moved into a larger building in December 2018 with the Department of Health and a community medical clinic, which has increased collaborative efforts between their agencies and the integration of physical and behavioral health services. In addition, SJCC continues to collaborate with the Federally Qualified Health Care Center (FQHC) in San Juan County, Criminal Justice Services, Tribal organizations and other community partners, which has increased access to services in the community.
- 2) Medication Assisted Treatment (MAT): SJCC has increased access to MAT in their community. Their Advanced Practice Registered Nurse (APRN) is now able to prescribe Suboxone, which has increased access to services for individuals with opioid use disorders. In addition, MAT is being assessed at intake and included in the client’s treatment plan if indicated. The use of MAT has improved outcomes for individuals with opioid use disorders in San Juan County.
- 3) Gender Responsive and Evidenced Based Services: SJCC started a women’s specific Seeking Safety group, which has improved outcomes for women attending this group. In addition, they hired a therapist who specializes in Motivational Interviewing to assist with evidence-based treatment and is working on increasing fidelity measures in their program. SJCC continues to seek innovative methods of individualizing services, increasing evidence-based services and improving the quality of treatment.

- 4) Recovery Support Services: SJCC hired a recovery support coordinator through JRI funds who has helped improve collaborative efforts between the criminal justice system, SJCC and the community. The recovery support coordinator has been meeting with client's in the jail and after they have been discharged to connect them to services at SJCC and the community. This has helped improve outcomes for clients involved with the criminal justice system.

Section Two: Report Information

Background

Utah Code Section 62A-15-103 outlines duties of the Division of Substance Abuse and Mental Health. Paragraph (2)(c) states that the Division shall:

- Consult and coordinate with local substance abuse authorities and local mental health authorities regarding programs and services,
- Provide consultation and other assistance to public and private agencies and groups working on substance abuse and mental health issues,
- Receive, distribute, and provide direction over public funds for substance abuse and mental health services,
- Monitor and evaluate programs provided by local substance abuse authorities and mental health authorities,
- Examine expenditures of any local, state and federal funds,
- Monitor the expenditure of public funds by local substance abuse authorities and mental health authorities,
- Contract with local substance abuse authorities and mental health authorities to provide a continuum of services in accordance with division policy, contract provisions, and the local plan,
- Assure that these requirements are met and applied uniformly by local substance abuse authorities and mental health authorities across the state,
- Conduct an annual program audit and review of each local substance abuse authority and mental health authority in the state and its contract provider in a review and determination that public funds allocated to by local substance abuse authorities and mental health authorities are consistent with services rendered and outcomes reported by them or their contract providers,
- Each local substance abuse authority and each mental health authority is exercising sufficient oversight and control over public funds allocated for substance abuse and mental health programs and services, and
- Other items determined by the division to be necessary and appropriate.

Non-Compliance Issues, Action Plans and Timelines

This report is organized into individual sections, in which inadequacies will be identified and discussed. Inadequacies are assigned a level of severity based on the combined judgment of the monitoring team. In order to fully understand the degree of severity, a short discussion of the inadequacy levels follows.

A **major non-compliance issue** is non-compliance in contract requirements which affect the imminent health, safety, or well-being of individuals. In cases of non-compliance at this level, a written corrective action plan must be completed by the Local Authority immediately and compliance must be achieved within 24 hours or less.

It should be noted that in extreme cases where, in the professional opinion of the monitoring team, an elevated threat of imminent health, safety, or well-being of individuals exists, contract payments may be suspended indefinitely.

A **significant non-compliance issue** is either 1) non-compliance with contract requirements that do not pose an imminent danger to clients but that result in inadequate treatment or care that jeopardizes the well-being of individuals; OR 2) non-compliance in required training, paperwork, and/or documentation that are so severe or pervasive as to jeopardize the effectiveness of services and continued contract funding. This type of finding will also require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 10 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 30 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **minor non-compliance issue** results when the reviewers identify a performance inadequacy that is relatively small in scope and does not impact client well-being or jeopardize funding. This type of finding will require the submission of a written corrective action plan in which the Local Authority identifies the steps it will take to rectify the issue and a time frame for accomplishing the correction. The due date for this submission shall be within 15 working days of receipt of the draft monitoring report by the Local Authority. Compliance must be achieved within 60 days of receipt of the draft monitoring report. Verification of the resolution may be accomplished in several ways including a follow-up visit, measurement during the next site review, a review of training documentation, a review of data submitted subsequent to the correction or a combination of these or any other method determined adequate to measure the resolution.

A **deficiency** results when the contractor is not in full compliance, but the deficiency discovered is not severe enough to be categorized as a non-compliance issue. A written corrective action

plan is required without a formal timeline. However, the monitoring team may request action to fix the problem by a given date.

A **recommendation** occurs when the contractor is in compliance. The Division is simply making a best practice or technical suggestion. The contractor is encouraged to implement the suggestion but not required.

In rare instances, a non-compliance issue from a previous year may continue unresolved at the time of the monitoring site visit. A recurring non-compliance issue will be prominently displayed in the current monitoring report and will require special attention by the Local Authority to ensure its immediate resolution.

Signature Page

We appreciate the cooperation afforded the Division monitoring teams by the management, staff and other affiliated personnel of San Juan Counseling Center and for the professional manner in which they participated in this review.

If there are any questions regarding this report please contact Chad Carter at (801)538-4072.

The Division of Substance Abuse and Mental Health

Prepared by:

Chad Carter Chad Carter Date March 26, 2019
Auditor IV

Approved by:

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Administrative Services Director

Eric Tadehara Eric Tadehara Date March 26, 2019
Assistant Director Children’s Behavioral Health

Jeremy Christensen Jeremy Christensen Date March 26, 2019
Assistant Director Mental Health

Brent Kelsey Brent Kelsey Date March 29, 2019
Assistant Director Substance Abuse

Doug Thomas Doug Thomas Date March 29, 2019
Division Director


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